General

Guideline Title

Neoadjuvant chemotherapy for newly diagnosed, advanced ovarian cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology clinical practice guideline.

Bibliographic Source(s)

Wright AA, Bohlke K, Armstrong DK, Bookman MA, Cliby WA, Coleman RL, Dizon DS, Kash JJ, Meyer LA, Moore KN, Olawaiye AB, Oldham J, Salani R, Sparacio D, Tew WP, Vergote I, Edelson MI. Neoadjuvant chemotherapy for newly diagnosed, advanced ovarian cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology clinical practice guideline. J Clin Oncol. 2016 Oct 1;34(28):3460-73. [55 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Definitions for the rating of evidence (High, Intermediate, Low, Insufficient); types of recommendations (Evidence based, Formal consensus, Informal consensus, No recommendation); and strength of recommendations (Strong, Moderate, Weak) are provided at the end of the "Major Recommendations" field.

Clinical Question 1

What clinical evaluations should be performed in all women with suspected or newly diagnosed stage IIIC or IV epithelial ovarian cancer?

Recommendation 1.1: All women with suspected stage IIIC or IV invasive epithelial ovarian cancer should be evaluated by a gynecologic oncologist prior to initiation of therapy to determine whether they are candidates for primary cytoreductive surgery (PCS). (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: strong.)

Recommendation 1.2: A primary clinical evaluation should include a computed tomography (CT) of the abdomen and pelvis with oral and intravenous contrast and chest imaging (CT preferred) to evaluate the extent of disease and the feasibility of surgical resection. The use of other tools to refine this assessment may include laparoscopic evaluation or additional radiographic imaging (e.g., [^{18}F] fluorodeoxyglucose positron-emission tomography [FDG-PET] scan or diffusion-weighted magnetic resonance imaging [MRI]). (Type: informal consensus; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate.)

Clinical Question 2

Which patient and disease factors should be used as criteria for identifying patients who are not suitable for PCS?

Recommendation 2.1: Women who have a high perioperative risk profile or a low likelihood of achieving cytoreduction to <1 cm (ideally to no visible disease) should receive neoadjuvant chemotherapy (NACT). (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate.)

Recommendation 2.2: Decisions that women are not eligible for medical or surgical cancer treatment should be made after a consultation with a gynecologic oncologist and/or a medical oncologist with gynecologic expertise. (Type: informal consensus; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate.)

Clinical Question 3

How do NACT and PCS compare with respect to progression-free survival, overall survival, and perioperative morbidity and mortality in women with newly diagnosed stage IIIC or IV epithelial ovarian cancer who are fit for primary cytoreduction and have potentially resectable disease, and how should this information be used to select initial treatment?

Recommendation 3.1: For women who are fit for PCS, with potentially resectable disease, either NACT or PCS may be offered based on data from phase III randomized controlled trials (RCTs) that demonstrate that NACT is noninferior to PCS with respect to progression-free and overall survival. NACT is associated with less peri- and postoperative morbidity and mortality and shorter hospitalizations, but PCS may offer superior survival in selected patients. (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate.)

Recommendation 3.2: For women with a high likelihood of achieving a cytoreduction to <1 cm (ideally to no visible disease) with acceptable morbidity, PCS is recommended over NACT. (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate.)

Recommendation 3.3: For women who are fit for PCS but are deemed unlikely to have cytoreduction to <1 cm (ideally to no visible disease) by a gynecologic oncologist, NACT is recommended over PCS. NACT is associated with less peri- and postoperative morbidity and mortality and shorter hospitalizations. (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate.)

Clinical Question 4

What additional clinical evaluations should be performed in all women with suspected or newly diagnosed stage IIIC or IV epithelial ovarian cancer before NACT is delivered?

Recommendation 4: Before NACT is delivered, all patients should have histologic confirmation (core biopsy preferred) of an invasive ovarian, fallopian tube, or peritoneal cancer. In exceptional cases, when a biopsy cannot be performed, cytologic evaluation combined with a serum cancer antigen (CA)-125 to carcinoembryonic antigen (CEA) ratio >25 is acceptable to confirm the primary diagnosis and exclude cancers that are not ovarian, fallopian tube, or primary peritoneal carcinomas (Type: informal consensus; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate.)

Clinical Question 5

What is the preferred chemotherapy regimen for women with stage IIIC or IV epithelial ovarian cancer who will receive NACT?

Recommendation 5

For NACT, a platinum/taxane doublet is recommended. However, alternate regimens, containing a platinum agent, may be selected based on individual patient factors. (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate.)

Clinical Question 6

Among women treated with NACT, does the timing of interval cytoreductive surgery (ICS) or the number of chemotherapy cycles after ICS affect the safety or efficacy of treatment?

Recommendation 6

RCTs tested surgery following three or four cycles of chemotherapy in women who had a response to NACT or stable disease. ICS should be performed after ≤4 cycles of NACT for women with a response to chemotherapy or stable disease. Alternate timing of surgery has not been

prospectively evaluated but may be considered based on patient-centered factors. (Type: informal consensus; benefits outweigh harms; Evidence quality: insufficient; Strength of recommendation: weak.)

Clinical Question 7

What are the treatment options for patients with progressive disease on NACT?

Recommendation 7

Patients with progressive disease on NACT have a poor prognosis. Options include alternative chemotherapy regimens, clinical trials, and/or discontinuation of active cancer therapy and initiation of end-of-life care. In general, there is little role for surgery and it is not typically advised, unless for palliation (e.g., relief of a bowel obstruction). (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: strong.)

Definitions

Guide for Rating Quality of Evidence

Rating for Strength of Evidence	Definition
High	High confidence that the available evidence reflects the true magnitude and direction of the net effect (i.e., balance of benefits versus harms) and that further research is very unlikely to change either the magnitude or direction of this net effect.
Intermediate	Moderate confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research is unlikely to alter the direction of the net effect; however, it might alter the magnitude of the net effect.
Low	Low confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research may change either the magnitude and/or direction this net effect.
Insufficient	Evidence is insufficient to discern the true magnitude and direction of the net effect. Further research may better inform the topic. The use of the consensus opinion of experts is reasonable to inform outcomes related to the topic.

Guide for Types of Recommendations

Type of Recommendation	Definition
Evidence based	There was sufficient evidence from published studies to inform a recommendation to guide clinical practice.
Formal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. Therefore, the Expert Panel used a formal consensus process to reach this recommendation, which is considered the best current guidance for practice. The Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak"). The results of the formal consensus process are summarized in the guideline and reported in the Data Supplement (see the "Availability of Companion Documents" field).
Informal Consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. The recommendation is considered the best current guidance for practice, based on informal consensus of the Expert Panel. The Panel agreed that a formal consensus process was not necessary for reasons described in the literature review and discussion. The Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak").
No recommendation	There is insufficient evidence, confidence, or agreement to provide a recommendation to guide clinical practice at this time. The Panel deemed the available evidence as insufficient and concluded it was unlikely that a formal consensus process would achieve the level of agreement needed for a recommendation.

Guide for Rating Strength of Recommendations

Rating for Strength of Recommendation	Definition
Strong	There is high confidence that the recommendation reflects best practice. This is based on (1) strong evidence for a true

Rating for Strength of Recommendation	Definition
	net effect (e.g., benefits exceed harms); (2) consistent results, with no or minor exceptions; (3) minor or no concerns about study quality; and/or (4) the extent of panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a strong recommendation.
Moderate	There is moderate confidence that the recommendation reflects best practice. This is based on (1) good evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with minor and/or few exceptions; (3) minor and/or few concerns about study quality; and/or (4) the extent of panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a moderate recommendation.
Weak	There is some confidence that the recommendation offers the best current guidance for practice. This is based on (1) limited evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, but with important exceptions; (3) concerns about study quality; and/or (4) the extent of panelists' agreement. Other considerations (discussed in the guideline's literature review and analyses) may also warrant a weak recommendation.

Clinical Algorithm(s)

An algorithm titled "Algorithm for the Clinical Evaluation and Treatment of Women with Suspected Stage IIIC or IV Epithelial Ovarian Cancer, Fallopian Tube Cancer, or Primary Peritoneal Cancer" is available in the original guideline document.

Scope

Disease/Condition(s)

Stage IIIC or IV epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer

Guideline Category

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Nuclear Medicine

Obstetrics and Gynecology

Oncology

Radiology

Surgery

Intended Users

Advanced Practice Nurses

Patients

Physician Assistants

Physicians

Guideline Objective(s)

To provide clinicians with information regarding the use of neoadjuvant chemotherapy (NACT) and interval cytoreduction versus primary cytoreduction and chemotherapy among women with stage IIIC or IV epithelial ovarian cancer

Target Population

Women with newly diagnosed or suspected stage IIIC or IV epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer

Interventions and Practices Considered

Risk Assessment/Evaluation

1. Evaluation by a gynecologic oncologist
2. Computed tomography (CT) scan of the abdomen and pelvis with oral and intravenous contrast and chest imaging (CT preferred)
3. Laparoscopic evaluation or additional radiographic imaging (e.g., [^{18}F]fluorodeoxyglucose positron-emission tomography [FDG-PET] scan or diffusion-weighted magnetic resonance imaging [MRI])
4. Establishing a risk profile for perioperative morbidity
5. Histologic confirmation (core biopsy preferred) of an invasive ovarian, fallopian tube, or peritoneal cancer
6. Cytologic evaluation combined with a serum cancer antigen (CA)-125 to carcinoembryonic antigen (CEA) ratio >25

Treatment/Management

1. Consultation with a gynecologic oncologist and/or a medical oncologist with gynecologic expertise prior to making decisions about treatment
2. Neoadjuvant chemotherapy (NACT)
    - Platinum/taxane doublet
    - Alternate regimens containing a platinum agent
3. Primary cytoreductive surgery (PCS)
4. Interval cytoreductive surgery (ICS)
5. Entrance into clinical trials
6. Discontinuation of active cancer therapy
7. Initiation of end-of-life care

Major Outcomes Considered

- Progression-free survival
- Overall survival
- Perioperative morbidity and mortality
- Sensitivity, specificity, and accuracy of imaging and pathological tests
- Reproducibility and prognostic value of histopathologic scoring systems

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Literature Search Strategy

PubMed, the Cochrane Collaboration Library electronic databases, and meeting abstracts from American Society of Clinical Oncology (ASCO), the Society of Gynecologic Oncology (SGO), or the European Society for Medical Oncology (ESMO) were searched for evidence reporting on outcomes of interest. Further details on the search strategy and results are provided in Data Supplements 3 and 4 (see the "Availability of Companion Documents" field).

Guideline Development Process

Panelists considered evidence from a systematic review of phase III randomized controlled trials (RCTs), meta-analyses, and multicenter cohort studies published between March 20, 2005, and March 20, 2015. A list of search terms is provided in the Data Supplement (see the "Availability of Companion Documents" field). Meeting abstracts were included if they provided results from still-unpublished RCTs and were presented at meetings of ASCO, SGO, or ESMO from 2010 to 2015.

Articles were selected for inclusion in the systematic review of the evidence based on the following criteria:

- Population: Women with newly diagnosed stage III or stage IV epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer.
- Study type: Evidence regarding the outcomes of neoadjuvant chemotherapy (NACT) was drawn from published or presented phase III RCTs. Evidence regarding predictive and prognostic factors in advanced ovarian cancer was drawn from RCTs, multicenter cohort studies, meta-analyses, and population-based observational data. Inclusion of influential single center cohort studies was made at the discretion of the panel.

Articles were excluded from the systematic review if they were editorials, commentaries, letters, news articles, case reports, narrative reviews, or published in a non-English language.

Number of Source Documents

Four randomized controlled trials (RCTs) met eligibility criteria and form the primary evidence base for the guideline recommendations.

Information about prognostic and predictive factors in ovarian cancer was collected from nine multicenter or population-based cohort studies, three single-center cohort studies, and one meta-analysis.

A Quality of Reporting of Meta-analyses (QUOROM) Diagram that reports the results of the literature search is available in Data Supplement 4 (see the "Availability of Companion Documents" field).

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Guide for Rating Quality of Evidence

Rating for Strength of Evidence	Definition
High	High confidence that the available evidence reflects the true magnitude and direction of the net effect (i.e., balance of benefits versus harms) and that further research is very unlikely to change either the magnitude or direction of this net effect.
Intermediate	Moderate confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research is unlikely to alter the direction of the net effect; however, it might alter the magnitude of the net effect.
Low	Low confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research may change either the magnitude and/or direction this net effect.
Insufficient	Evidence is insufficient to discern the true magnitude and direction of the net effect. Further research may better inform the topic. The use of the consensus opinion of experts is reasonable to inform outcomes related to the topic.

Guide for Rating of Potential for Bias

Rating of Potential for Bias	Definitions for Rating Potential for Risk of Bias in Randomized Controlled Trials
Low risk	No major features in the study that risk biased results, and none of the limitations are thought to decrease the validity of the conclusions. The study avoids problems such as failure to apply true randomization, selection of a population unrepresentative of the target patients, high dropout rates, and no intention-to-treat analysis; and key study features are described clearly (including the population, setting, interventions, comparison groups, measurement of outcomes, and reasons for dropouts).
Intermediate	The study is susceptible to some bias, but flaws are not sufficient to invalidate the results. Enough of the items introduce some uncertainty about the validity of the conclusions. The study does not meet all the criteria required for a rating of good quality, but no flaw is likely to cause major bias. The study may be missing information, making it difficult to assess limitations and potential problems.
High risk	There are significant flaws that imply biases of various types that may invalidate the results. Several of the items introduce serious uncertainty about the validity of the conclusions. The study has serious errors in design, analysis, or reporting; large amounts of missing information; or discrepancies in reporting.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Data Extraction

Literature search results were reviewed and deemed appropriate for full text review by one American Society of Clinical Oncology (ASCO) staff reviewer in consultation with the Expert Panel Co-Chairs. Data were extracted by one staff reviewer and subsequently checked for accuracy through an audit of the data by another ASCO staff member. Disagreements were resolved through discussion and consultation with the Co-Chairs if necessary. Evidence tables are provided in the original guideline document and in Data Supplements 1 and 2 (see the "Availability of Companion Documents" field).

Study Quality Assessment

Study quality was formally assessed for the studies identified. Design aspects related to the individual study quality were assessed by one reviewer and included factors such as blinding, allocation concealment, placebo control, intention to treat, funding sources, etc. The risk of bias is assessed as "low," "intermediate," or "high" for most of the identified evidence.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Panel Composition

The American Society of Clinical Oncology (ASCO) Clinical Practice Guidelines Committee (CPGC), in collaboration with the Society of Gynecologic Oncology (SGO), convened an Expert Panel with multidisciplinary representation in medical oncology, gynecologic oncology, community oncology, patient/advocacy representation, and guideline implementation. The Expert Panel was led by two Co-Chairs who had primary responsibility for the development and timely completion of the guideline. For this guideline product, the Co-Chairs selected additional members from the Expert Panel to form a Writing Group to assist in the development and review of the guideline drafts.

Guideline Development Process

The Expert Panel met four times and corresponded frequently through e-mail; progress on guideline development was driven primarily by the Co-Chairs along with ASCO and SGO staff. The purpose of the meetings was for members to contribute content, provide critical review, interpret evidence, and finalize the guideline recommendations based upon the consideration of the evidence. All members of the Expert Panel participated in the preparation of the draft guideline document.

Development of Recommendations

The guideline recommendations were crafted, in part, using the GuideLines Into DEcision Support (GLIDES) methodology and accompanying BRIDGE-Wiz software™. This method helps guideline panels systematically develop clear, translatable, and implementable recommendations using natural language, based on the evidence and assessment of its quality to increase usability for end users. The process incorporates distilling the actions involved, identifying who will carry them out, to whom, under what circumstances, and clarifying if and how end users can carry out the actions consistently. This process helps the Panel focus the discussion, avoid using unnecessary and/or ambiguous language, and clearly state its intentions.

Rating Scheme for the Strength of the Recommendations

Guide for Types of Recommendations

Type of Recommendation	Definition
Evidence based	There was sufficient evidence from published studies to inform a recommendation to guide clinical practice.
Formal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. Therefore, the Expert Panel used a formal consensus process to reach this recommendation, which is considered the best current guidance for practice. The Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak"). The results of the formal consensus process are summarized in the guideline and reported in the Data Supplement (see the "Availability of Companion Documents" field).
Informal Consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. The recommendation is considered the best current guidance for practice, based on informal consensus of the Expert Panel. The Panel agreed that a formal consensus process was not necessary for reasons described in the literature review and discussion. The Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak").
No recommendation	There is insufficient evidence, confidence, or agreement to provide a recommendation to guide clinical practice at this time. The Panel deemed the available evidence as insufficient and concluded it was unlikely that a formal consensus process would achieve the level of agreement needed for a recommendation.

Guide for Strength of Recommendations

Rating for Strength of Recommendation	Definition
Strong	There is high confidence that the recommendation reflects best practice. This is based on (1) strong evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with no or minor exceptions; (3) minor or no concerns about study quality; and/or (4) the extent of panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a strong recommendation.
Moderate	There is moderate confidence that the recommendation reflects best practice. This is based on (1) good evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with minor and/or few exceptions; (3) minor and/or few concerns about study quality; and/or (4) the extent of panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a moderate recommendation.
Weak	There is some confidence that the recommendation offers the best current guidance for practice. This is based on (1) limited evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, but with important exceptions; (3) concerns about study quality; and/or (4) the extent of panelists' agreement. Other considerations (discussed in the guideline's literature review and analyses) may also warrant a weak recommendation.

Cost Analysis

Cost Implications

Decisions between primary cytoreductive surgery (PCS) and neoadjuvant chemotherapy (NACT) should be driven by the expected clinical risks and benefits rather than by cost. Nevertheless, cost may warrant consideration when the two treatment options appear similarly beneficial, or when cost is an important concern for the patient. The comparative cost of PCS and NACT has been evaluated using observational data from SEER-Medicare. Among 4,506 older women with advanced ovarian cancer, the costs associated with PCS and NACT were similar for women with stage IIIC disease, but PCS was associated with higher costs in women with stage IV disease. The cost of care among older women (age ≥65 years) with advanced ovarian cancer has also been evaluated using a 5-year Markov model, which assumed similar overall survival with PCS and NACT based upon the results of European Organisation for Research and Treatment of Cancer (EORTC) 55971. In this study, NACT was associated with a cost savings of $5,616 compared with PCS, when costs included surgery, chemotherapy, and hospital stays. To date, researchers have not included quality-adjusted life-years in comparisons of the costs between PCS and NACT. Given the limitations of current data, the relative costs of the two treatment approaches remain uncertain.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Members of the Expert Panel were responsible for reviewing and approving the penultimate version of guideline, which was then circulated for external review and submitted to *Gynecologic Oncology* and the *Journal of Clinical Oncology* (*JCO*) for editorial review and consideration for publication. The guideline was also reviewed and approved by the American Society of Clinical Oncology (ASCO), Clinical Practice Guidelines Committee, Society of Gynecologic Oncology (SGO) Publications, and the SGO Clinical Practice Committees prior to publication.

The ASCO Clinical Practice Guidelines Committee approved this guideline on January 25, 2016.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate use of neoadjuvant chemotherapy (NACT) and interval cytoreduction among women with advanced epithelial ovarian cancer

Refer to the "Literature review and analysis" and "Clinical interpretation" sections of the original guideline document for detailed discussions of the potential benefits and harms of each recommendation.

Potential Harms

Both cytoreductive surgery and chemotherapy are associated with adverse events, including mortality.

Refer to the "Literature review and analysis" and "Clinical interpretation" sections of the original guideline document for detailed discussions of the potential benefits and harms of each recommendation.

Contraindications

Contraindications

Patients who develop progressive disease during neoadjuvant chemotherapy (NACT) should avoid interval cytoreductive surgery (ICS) unless they have a demonstrated response to an alternate chemotherapy. It is very unlikely that an optimal surgical cytoreduction can be achieved in patients with primary platinum-refractory disease, and the survival benefit of a potentially morbid surgery is uncertain in this context.

Qualifying Statements

Qualifying Statements

- The Clinical Practice Guidelines and other guidance published herein are provided by the American Society of Clinical Oncology, Inc. (ASCO) to assist providers in clinical decision making. The information herein should not be relied upon as being complete or accurate, nor should it be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. With the rapid development of scientific knowledge, new evidence may emerge between the time information is developed and when it is published or read. The information is not continually updated and may not reflect the most recent evidence. The information addresses only the topics specifically identified therein and is not applicable to other interventions, diseases, or stages of diseases. This information does not mandate any particular course of medical care. Further, the information is not intended to substitute for the independent professional judgment of the treating provider, as the information does not account for individual variation among patients. Recommendations reflect high, moderate, or low confidence that the recommendation reflects the net effect of a given course of action. The use of words like "must," "must not," "should," and "should not" indicates that a course of action is recommended or not recommended for either most or many patients, but there is latitude for the treating physician to select other courses of action in individual cases. In all cases, the selected course of action should be considered by the treating provider in the context of treating the individual patient. Use of the information is voluntary. ASCO provides this information on an "as is" basis and makes no warranty, express or implied, regarding the information. ASCO specifically disclaims any warranties of merchantability or fitness for a particular use or purpose. ASCO assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this information, or for any errors or omissions.
- Refer to the "Health Disparities" and "Multiple Chronic Conditions" sections in the original guideline document for additional qualifying information.

Implementation of the Guideline

Description of Implementation Strategy

Guideline Implementation

American Society of Clinical Oncology (ASCO) guidelines are developed for implementation across health settings. Barriers to implementation include the need to increase awareness of the guideline recommendations among front-line practitioners and survivors of cancer and caregivers, and to provide adequate services in the face of limited resources. The guideline Bottom Line Box was designed to facilitate implementation of recommendations. This guideline will be distributed widely through the ASCO Practice Guideline Implementation Network. ASCO guidelines are posted on the ASCO Web site and most often published in the *Journal of Clinical Oncology* and the *Journal of Oncology Practice*.

For additional information on the ASCO implementation strategy, please see the ASCO Web site.

Implementation Tools

Clinical Algorithm

Patient Resources

Quick Reference Guides/Physician Guides

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Wright AA, Bohlke K, Armstrong DK, Bookman MA, Cliby WA, Coleman RL, Dizon DS, Kash JJ, Meyer LA, Moore KN, Olawaiye AB, Oldham J, Salani R, Sparacio D, Tew WP, Vergote I, Edelson MI. Neoadjuvant chemotherapy for newly diagnosed, advanced ovarian cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology clinical practice guideline. J Clin Oncol. 2016 Oct 1;34(28):3460-73. [55 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2016 Oct 1

Guideline Developer(s)

American Society of Clinical Oncology - Medical Specialty Society

Society of Gynecologic Oncology - Disease Specific Society

Source(s) of Funding

American Society of Clinical Oncology (ASCO)

Guideline Committee

Neoadjuvant Chemotherapy for Newly Diagnosed, Advanced Ovarian Cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology Clinical Practice Guideline Expert Panel

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Guideline and Conflicts of Interest

The Expert Panel was assembled in accordance with the American Society of Clinical Oncology's (ASCO's) Conflict of Interest Policy Implementation for Clinical Practice Guidelines ("Policy," found at http://www.asco.org/rwc). All members of the panel completed ASCO's disclosure form, which requires disclosure of financial and other interests, including relationships with commercial entities that are reasonably likely to experience direct regulatory or commercial impact as a result of promulgation of the guideline. Categories for disclosure include employment; leadership; stock or other ownership; honoraria; consulting or advisory role; speakers' bureau; research funding; patents, royalties, other intellectual property; expert testimony; travel, accommodations, expenses; and other relationships. In accordance with the Policy, the majority of the members of the panel did not disclose any relationships constituting a conflict under the Policy.

Authors' Disclosures and Potential Conflicts of Interest

The following represents disclosure information provided by authors of the guideline. All relationships are considered compensated. Relationships are self-held unless noted. I = Immediate Family Member, Inst = My Institution. Relationships may not relate to the subject matter of this manuscript. For more information about ASCO's conflict of interest policy, please refer to www.asco.org/rwc or jco.ascopubs.org/site/ifc .

Alexi A. Wright
No relationship to disclose

Kari Bohlke
No relationship to disclose

Deborah K. Armstrong
Consulting or Advisory Role: Morphotek, Eisai (I), Vertex
Research Funding: Clovis Oncology, AstraZeneca, Eisai (I), Exelixis (I)
Other Relationship: US Food and Drug Administration, Eviti

Michael A. Bookman
Employment: McKesson
Honoraria: Genentech/Roche
Consulting or Advisory Role: Boehringer Ingelheim, Genentech/Roche, AstraZeneca, Abbvie, Sanofi, Novartis, Immunogen, Endocyte, Gradalis, Oxigene, Vertex, Pfizer, Clovis Oncology, Tesaro

William A. Cliby
Research Funding: GamaMabs Pharma

Robert L. Coleman
Honoraria: National Comprehensive Cancer Network, Clovis Oncology, Genentech/Roche, Esperance Pharmaceuticals, Department of Defense-Congressionally Directed Medical Research Programs
Research Funding: AstraZeneca/MedImmune, Esperance Pharmaceuticals, OncoMed, Array BioPharma, Clovis Oncology, Amgen, Johnson & Johnson, Merrimack
Travel, Accommodations, Expenses: Millennium, Merck, Amgen, AstraZeneca/MedImmune, Array BioPharma, Merrimack, Gradalis, Bayer, Clovis Oncology

Don S. Dizon
Consulting or Advisory Role: UpToDate, Pfizer
Research Funding: Aeterna Zentaris

Joseph J. Kash
Speakers' Bureau: Novartis

Larissa A. Meyer
Honoraria: TRM Oncology
Research Funding: AstraZeneca

Kathleen N. Moore
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Alexander B. Olawaiye
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Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Journal of Clinical Oncology Web site.

Availability of Companion Documents

The following are available:

- Neoadjuvant chemotherapy for newly diagnosed, advanced ovarian cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology clinical practice guideline. Methodology supplement. Alexandria (VA): American Society of Gynecologic Oncology and American Society of Clinical Oncology; 2016. 18 p. Available from the Journal of Clinical Oncology Web site.
- Neoadjuvant chemotherapy for newly diagnosed, advanced ovarian cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology clinical practice guideline. Data supplements 1-4. Alexandria (VA): Society of Gynecologic Oncology and American Society of Clinical Oncology; 2016. 11 p. Available from the Journal of Clinical Oncology Web site.
- Neoadjuvant chemotherapy for newly diagnosed, advanced ovarian cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology clinical practice guideline. Slide set. Alexandria (VA): Society of Gynecologic Oncology and American Society of Clinical Oncology; 2016. 22 p. Available from the American Society of Clinical Oncology (ASCO) Web site.
- Neoadjuvant chemotherapy for newly diagnosed, advanced ovarian cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology clinical practice guideline. Summary of recommendations table. Alexandria (VA): Society of Gynecologic Oncology and American Society of Clinical Oncology; 2016. 3 p. Available from the ASCO Web site.
- Wright AA, Bohlke K, Edelson MI. Neoadjuvant chemotherapy for newly diagnosed, advanced ovarian cancer: Society of Gynecologic Oncology and American Society of Clinical Oncology clinical practice guideline summary. J Oncol Pract. 2016 Dec; 12(12):1254-7. Available from the Journal of Oncology Practice Web site.

Patient Resources

The following is available:

- New joint guideline on chemotherapy for advanced ovarian cancer. Patient information. [internet]. Alexandria (VA): American Society of Clinical Oncology (ASCO); 2016 Aug 8. Available from the Cancer.Net Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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